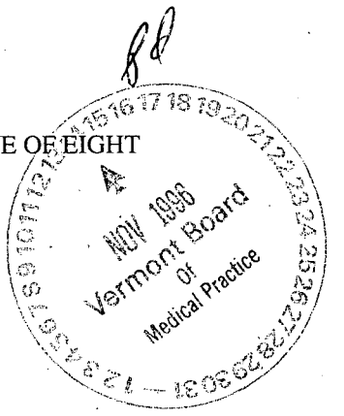
42-5990 SMITH, SUSAN

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1996 - 1998 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE ONE OF EIGHT



I hereby apply for the renewal of my LICENSE AS A PHYSICIAN for the period from 12/01/96 to 11/30/98. **TWO YEAR RENEWAL FEE: *$300.00*.**
Enclose a check in the amount of ***$300.00*** made payable to the Vermont Board of Medical Practice.

SUSAN SMITH
WOMENS CHOICE
23 MANSFIELD AVENUE
BURLINGTON, VT 05401

****

Important:
- Please print legibly or type your answers.
- Answer all questions completely - it is not adequate to state that the Board already has the information. Use the enclosed Form A to provide explanations to "yes" answers in Section II.
- Make a copy of this form and all attachments for your own records.
- Do not delegate this important task to an employee, as false statements on this form are grounds for unprofessional conduct.
- Do not remove any pages from this document.
-Thank you for your cooperation.

SECTION I

(Section I contains general information of interest to both the Board of Medical Practice and the Department of Health.)

1. Name: SUSAN SMITH

2. Vermont License Number: 42-5990

3. Other Name(s), if any, under which you were licensed in Vermont and elsewhere since your last renewal:

4. Home Address: _____

City, State, Zip Code: , VT _____

5. Office Address: WOMENS CHOICE _____

23 MANSFIELD AVENUE _____

City, State, Zip Code: BURLINGTON, VT 05401 _____

Note: Circle either "Home Address" or "Office Address" as your preferred mailing address.

6. Daytime Telephone Number: (802)863-9001 _____

7. Date of Birth: 1/26/44 _____

8. Sex (M/F): F

9. Are you currently active in clinical practice in Vermont? X Yes ___No

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1996 - 1998 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE TWO OF EIGHT

SECTION I CONTINUED

10. Licensing Examination Taken - Check: X National Boards ___FLEX ___State Examination-Identify State:
___USMLE ___Other Examination Specify:

11. Undergraduate Degree: (B.A., B.S., etc.): BS Year of Graduation: 1969

Major Course of Study: ZOOLOGY

Degree Granting Institution: UNIV MICHIGAN ANN AR

Location: ANN ARBOR, MI USA

First Institution (If transfer): _____

Location: _____

12. Medical Degree: (M.D. or Other, please specify): MD Year of Graduation: 1976

Degree Granting Medical School: _____

Location: ANN ARBOR, MI USA

First Medical School (If transfer): _____

Location: _____

13. Do you have hospital privileges **in Vermont?** X Yes ___No
Name(s) and Location(s) of Hospital(s):

(a) ~~FANNY ALLEN HOSPITAL~~

~~(b) MEDICAL CENTER HOSPITAL OF VERMONT~~

(c) FLETCHER ALLEN HEALTH CARE

(d) _____

(e) _____

14. Other states where you hold an active license to practice: NEW HAMPSHIRE

15. States where you were previously licensed to practice: _____

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1996 - 1998 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE THREE OF EIGHT

SECTION I CONTINUED

16. Please list your specialty(ies) and indicate if you are American Board of Medical Specialties certified in those specialties:

	Specialty Code	Specialty Name	Board Certified ([Y]es/[N]o)	Year Certified/Recertified
(a)	1 1 0 1	OBSTETRICS & GYNECOLOGY	Y	1982 /
(b)				/
(c)				/

17. Please list the institutions where you have had residency or fellowship training:

	Residency Institution #1	Residency Institution #2	Residency Institution #3
Institution Name	MCHV		
City	BURLINGTON		
State	VT		
Country	USA		
Specialty Code (See list)	1 1 0 1		
Specialty Name	OBSTETRICS & GYNECOLOGY		
Year Residency Completed	1980		

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1996 - 1998 PHYSICIAN LICENSE RENEWAL APPLICATION, FOUR OF EIGHT

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42-5990 SMITH, SUSAN

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1996 - 1998 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE FIVE OF EIGHT

SECTION II: PLEASE CHECK YES OR NO.
A "YES" ANSWER REQUIRES AN EXPLANATION ON THE ENCLOSED FORM A.
(Section II is for the reporting of information, which is retained solely by the Board of Medical Practice and is **not** part of the data base maintained by the Department of Health.)

During the past two years:

1. Have you had any organic illness, emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine, resident or fellow? [redacted]

2. Have you been a defendant in any criminal proceeding other than minor traffic offenses? ___YES _X_NO

3. Are you currently under investigation for a criminal act? [redacted]

4 Have you been dependent upon alcohol or drugs? [redacted]

5. Are any formal disciplinary charges pending or has any disciplinary action been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)? ___YES _X_NO

6. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim/complaint/demand for damages)? [redacted]

7. Have you had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, resigned from a medical staff in lieu of disciplinary action or resigned from a medical staff after a complaint or peer review action has been initiated against you? ___YES _X_NO

8. Have you voluntarily surrendered or resigned a license to practice medicine or any healing art in lieu of disciplinary action? ___YES _X_NO

9. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered by any jurisdiction or federal agency at any time? ___YES _X_NO

10. Have you been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill? ___YES _X_NO

11. Have you withdrawn an application for a medical license or been denied a medical license for any reason? ___YES _X_NO

12. Have you been turned down for coverage by a malpractice insurance carrier? ___YES _X_NO

13. Have you been notified as a responsible party of a confirmed quality concern (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? ___YES _X_NO

14. Have you been the subject of an investigation by any **other licensing board**? [redacted]

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1996 - 1998 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE SIX OF EIGHT

SECTION II CONTINUED

15. Have you been dismissed or asked to leave a residency training program(s) before completion? ___YES _X_NO

IMPORTANT NOTE REGARDING THE QUESTIONS ABOVE AND ON THE PREVIOUS PAGE:

Except for questions 1 and 4, "Yes" answers on past license renewals must be updated on Form A. For example, if a previously reported malpractice action has been dismissed, please indicate that on Form A. You have a continuing obligation to update the Board during the 1996-1998 period if the answer to any of the questions above changes from "No" to "Yes".

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1996 - 1998 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE SEVEN OF EIGHT

SECTION III

Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions

IMPORTANT: WITHOUT EXCEPTION, ALL LICENSEES MUST COMPLETE (1), (2), (3), (4) AND (5) BELOW OR THE LICENSE WILL NOT BE RENEWED. THANK YOU FOR YOUR COOPERATION.

Regarding Child Support

Title 15 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. "Good standing" means that less than one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved by the office of child support or agreed to by the parties; or, the licensing authority determines that immediate payment of support would impose an unreasonable hardship. (15 V.S.A. § 795)

1. You must check one of the two statements below regarding child support regardless whether or not you have children:

__X__ I hereby certify that as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.

or

_____ I hereby certify that I am **NOT** in good standing with respect to child support due as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Taxes

Title 32 § 3113 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with the Department of Taxes. "Good Standing" means that no taxes are due, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)

2. You must check one of the two statements below:

__X__ I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a $10,000.00 fine or both).

or

_____ I hereby certify that I am **NOT** in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship".

(continued on page 8)

YOU MUST COMPLETE OTHER SIDE

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1996 - 1998 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE EIGHT OF EIGHT

SECTION III CONTINUED

Regarding Unemployment Compensation Contributions

Title 21 § 1378 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business (including a license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services or real estate space with any employing unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the employing unit is in good standing with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of contributions due as of the date such declaration is made. For the purposes of this section, a person is in good standing with respect to any and all contributions or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) the liability for any contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a payment plan approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions or payments in lieu of contributions due and payable would impose an unreasonable hardship.

3. **You must check one of the two statements below regarding unemployment contributions or payments in lieu of unemployment contributions:**

X I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment contributions to the Vermont Department of Employment and Training due as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a $10,000.00 fine or both).

or

____ I hereby certify that I am **NOT** in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an "Application for Hardship".

4. **SOCIAL SECURITY NUMBER:** [redacted] * DATE OF BIRTH: 1/26/44

* The disclosure of your social security number is mandatory, is solicited by the authority granted by 42 U.S.C. § 405(c)(2)(C), and will be used by the Department of Taxes and the Department of Employment and Training, in the administration of tax laws, to identify individuals affected by such laws, and by the Office of Child Support.

5. **STATEMENT OF APPLICANT**

I further certify that all information contained in this renewal application (including all pages and attachments) is true and accurate to the best of my knowledge. *Failure to provide truthful and accurate information may constitute grounds for denial of license renewal or disciplinary action.*

Date: 10/30/96 Signature: Susan Smith

Return the completed form and fee to:
(Return envelope enclosed)

Vermont Board of Medical Practice
109 State Street
Montpelier, Vermont 05609-1106

QUESTIONS?: (802) 828-2673

IMPORTANT: Please be sure to write your license number on your check. Check for the correct spelling of your name and proper address on the page one label. Print any changes in the adjoining space. Sign and date the application. Enclose the correct fee of $300.00* in check or money order payable to the Vermont Board of Medical Practice.

***Note:** Physicians 80 years of age or older are exempt from payment of a renewal fee; however the physician license renewal application must be completed and submitted.

SECTION IV

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV

(Section IV is especially for the needs of health care access planning/physician recruitment and retention efforts in Vermont)

1. (a) Check **all** of the activities that describe your current status as a physician:
   - X Active in clinical practice in Vermont
   - __ Active in clinical practice outside Vermont
   - __ Administration
   - X Teaching
   - __ Research
   - __ Retired
   - __ Other

   (b) How many hours per week do you spend on administration, teaching and research? 3 hours

2. Postgraduate training in Vermont:
   (a) Are you currently in a postgraduate training program in Vermont as a resident or clinical fellow?
   __Yes X No **Note: If you answered YES, please answer questions (b) and (c)**
   (b) Are you a ___Resident ___Clinical Fellow ___Research Fellow?
   (c) What is the medical school that you are affiliated with for this training?
   ___University of Vermont ___Dartmouth ___Other (Please specify)_____

***** Note: If you are providing patient care in Vermont, CONTINUE.**
Otherwise, STOP and return this survey with your relicensing application.

3. What is the date you started practicing medicine (excluding residency or fellowship training)?
   (Month/Year) 08/1980

4. What is the date you started practicing medicine in Vermont (excluding residency or fellowship training)?
   (Month/Year) 08/1980

5. Do you plan to retire or reduce your patient care hours in the next 12 months? ___Yes X No

SECTION IV CONTINUED

Instructions for completing this portion:

* Estimate if exact figures are not available.
* Please complete a WORK SITE section for each location where you provide patient care.
* Do not include, as a separate site, hospitals and nursing homes where you provide care to patients normally seen in an outpatient/office setting.
* Be as detailed as possible.
* Use the enclosed yellow sheet to make selections for the Specialty Code and Specialty Name columns.
* Do not remove any pages from this document.

6(a). WORK SITE: NUMBER ONE

Town: ST. ALBANS CITY County: FRANKLIN

(*Note: Enter the town and county in which the site is located, not a mailing address or Post Office box.)

Check the **ONE** practice setting from the selections below that most accurately reflects your practice at this site:

PRACTICE SETTINGS

___ Solo Practice
___ Group Practice
___ Community Health Center or Clinic (Non-Hospital)
___ Hospital Outpatient Clinic
___ School or College Health Center
___ Business or Work Site
___ Hospital Emergency Room
___ Hospital Inpatient
___ Extended Care Facility / Nursing Home
___ Other: Specify Family Planning Clinic

Average hours per week that you spend at this site providing DIRECT PATIENT CARE. **Include** both AMBULATORY CARE and HOSPITAL CARE of patients who originate from this site. Please **exclude** on-call hours.

Please complete one full line for each SPECIALTY that YOU practice at this site:

	Specialty Code	Specialty Name	Hours Per Week
Primary Specialty at this Site	4011	GYNECOLOGY	6 +
Secondary Specialty at this Site			
Other Specialty at this Site			

Do you plan to continue practice at this site for the next 12 months? X Yes ___No

Will you accept new patients at this site? X Yes ___No

Will you accept new Medicaid patients at this site? X Yes ___No

Will you accept new Medicare patients at this site? X Yes ___No

Are you working with physician's assistants and/or nurse practitioners at this site? X Yes ___No
If yes, enter the number of: Physician's Assistants 1 Nurse Practitioners _____

For FAMILY and GENERAL PRACTITIONERS, PEDIATRICIANS and INTERNISTS (primary care): Do you provide primary care services to adolescents (ages 10-20) at this site? ___Yes ___No

For FAMILY and GENERAL PRACTITIONERS: Which of the following obstetrical services do you provide to patients from this site? _____Prenatal care and delivery _____Prenatal care only _____No obstetrical services provided

SECTION IV CONTINUED

Instructions for completing this portion:

* Estimate if exact figures are not available.
* Please complete a WORK SITE section for each location where you provide patient care.
* Do not include, as a separate site, hospitals and nursing homes where you provide care to patients normally seen in an outpatient/office setting.
* Be as detailed as possible.
* Use the enclosed yellow sheet to make selections for the Specialty Code and Specialty Name columns.
* Do not remove any pages from this document.

6(b). WORK SITE: NUMBER TWO

Town: BURLINGTON County: CHITTENDEN

(*Note: Enter the town and county in which the site is located, not a mailing address or Post Office box.)

Check the **ONE** practice setting from the selections below that most accurately reflects your practice at this site:

PRACTICE SETTINGS

- ___ Solo Practice
- X Group Practice
- ___ Community Health Center or Clinic (Non-Hospital)
- ___ Hospital Outpatient Clinic
- ___ School or College Health Center
- ___ Business or Work Site
- ___ Hospital Emergency Room
- ___ Hospital Inpatient
- ___ Extended Care Facility / Nursing Home
- ___ Other: Specify

Average hours per week that you spend at this site providing DIRECT PATIENT CARE. **Include** both AMBULATORY CARE and HOSPITAL CARE of patients who originate from this site. Please **exclude** on-call hours.

Please complete one full line for each SPECIALTY that YOU practice at this site:

	Specialty Code	Specialty Name	Hours Per Week
Primary Specialty at this Site	4 0 1 1	GYNECOLOGY	35 45
Secondary Specialty at this Site			
Other Specialty at this Site			

Do you plan to continue practice at this site for the next 12 months? X Yes ___No

Will you accept new patients at this site? X Yes ___No

Will you accept new Medicaid patients at this site? X Yes ___No

Will you accept new Medicare patients at this site? X Yes ___No

Are you working with physician's assistants and/or nurse practitioners at this site? ___Yes X No
If yes, enter the number of: Physician's Assistants _____ Nurse Practitioners _____

For FAMILY and GENERAL PRACTITIONERS, PEDIATRICIANS and INTERNISTS (primary care): Do you provide primary care services to adolescents (ages 10-20) at this site? ___Yes ___No

For FAMILY and GENERAL PRACTITIONERS: Which of the following obstetrical services do you provide to patients from this site? _____Prenatal care and delivery _____Prenatal care only _____No obstetrical services provided

SECTION IV CONTINUED

Instructions for completing this portion:

* Estimate if exact figures are not available.
* Please complete a WORK SITE section for each location where you provide patient care.
* Do not include, as a separate site, hospitals and nursing homes where you provide care to patients normally seen in an outpatient/office setting.
* Be as detailed as possible.
* Use the enclosed yellow sheet to make selections for the Specialty Code and Specialty Name columns.
* Do not remove any pages from this document.

6(c). WORK SITE: NUMBER THREE

Town: _____ County: _____

(*Note: Enter the town and county in which the site is located, not a mailing address or Post Office box.)

Check the **ONE** practice setting from the selections below that most accurately reflects your practice at this site:

PRACTICE SETTINGS

___ Solo Practice
___ Group Practice
___ Community Health Center or Clinic (Non-Hospital)
___ Hospital Outpatient Clinic
___ School or College Health Center
___ Business or Work Site
___ Hospital Emergency Room
___ Hospital Inpatient
___ Extended Care Facility / Nursing Home
___ Other: Specify

Average hours per week that you spend at this site providing DIRECT PATIENT CARE. **Include** both AMBULATORY CARE and HOSPITAL CARE of patients who originate from this site. Please **exclude** on-call hours.

Please complete one full line for each SPECIALTY that YOU practice at this site:

	Specialty Code	Specialty Name	Hours Per Week
Primary Specialty at this Site			
Secondary Specialty at this Site			
Other Specialty at this Site			

Do you plan to continue practice at this site for the next 12 months? ___Yes ___No

Will you accept new patients at this site? ___Yes ___No

Will you accept new Medicaid patients at this site? ___Yes ___No

Will you accept new Medicare patients at this site? ___Yes ___No

Are you working with physician's assistants and/or nurse practitioners at this site? ___Yes ___No
If yes, enter the number of: Physician's Assistants _____ Nurse Practitioners _____

For FAMILY and GENERAL PRACTITIONERS, PEDIATRICIANS and INTERNISTS (primary care): Do you provide primary care services to adolescents (ages 10-20) at this site? ___Yes ___No

For FAMILY and GENERAL PRACTITIONERS: Which of the following obstetrical services do you provide to patients from this site? _____Prenatal care and delivery _____Prenatal care only _____No obstetrical services provided

SECTION IV CONTINUED

Instructions for completing this portion:

* Estimate if exact figures are not available.
* Please complete a WORK SITE section for each location where you provide patient care.
* Do not include, as a separate site, hospitals and nursing homes where you provide care to patients normally seen in an outpatient/office setting.
* Be as detailed as possible.
* Use the enclosed yellow sheet to make selections for the Specialty Code and Specialty Name columns.
* Do not remove any pages from this document.

6(c). WORK SITE: NUMBER FOUR

Town: _____ County: _____

(*Note: Enter the town and county in which the site is located, not a mailing address or Post Office box.)

Check the **ONE** practice setting from the selections below that most accurately reflects your practice at this site:

PRACTICE SETTINGS

___ Solo Practice
___ Group Practice
___ Community Health Center or Clinic (Non-Hospital)
___ Hospital Outpatient Clinic
___ School or College Health Center
___ Business or Work Site
___ Hospital Emergency Room
___ Hospital Inpatient
___ Extended Care Facility / Nursing Home
___ Other: Specify

Average hours per week that you spend at this site providing DIRECT PATIENT CARE. **Include** both AMBULATORY CARE and HOSPITAL CARE of patients who originate from this site. Please **exclude** on-call hours.

Please complete one full line for each SPECIALTY that YOU practice at this site:

	Specialty Code	Specialty Name	Hours Per Week
Primary Specialty at this Site			
Secondary Specialty at this Site			
Other Specialty at this Site			

Do you plan to continue practice at this site for the next 12 months? ___Yes ___No

Will you accept new patients at this site? ___Yes ___No

Will you accept new Medicaid patients at this site? ___Yes ___No

Will you accept new Medicare patients at this site? ___Yes ___No

Are you working with physician's assistants and/or nurse practitioners at this site? ___Yes ___No
If yes, enter the number of: Physician's Assistants _____ Nurse Practitioners _____

For FAMILY and GENERAL PRACTITIONERS, PEDIATRICIANS and INTERNISTS (primary care): Do you provide primary care services to adolescents (ages 10-20) at this site? ___Yes ___No

For FAMILY and GENERAL PRACTITIONERS: Which of the following obstetrical services do you provide to patients from this site? _____Prenatal care and delivery _____Prenatal care only _____No obstetrical services provided

WOMEN'S CHOICE
GYNECOLOGIC ASSOCIATES

October 30, 1996

State of Vermont - Board of Medical Practice

RE: Non Suit

Because it has been brought to my attention that a harrassing non suit had been carried on PHICO's records as an open case, closed on 8/1/96, I am enclosing copies of correspondence from my lawyers to Scott Liebel of PHICO Insurance Company regarding that non suit. I examined the child of the plaintiff, brought in by her mother on 2/4/93, because the child had disclosed sexual abuse perpetrated by her father, the plaintiff in the non suit. I can send you copies of the letters from the plaintiff which demand information and threaten suit if I do not reply within X days to his questions. On advice from the state's attorneys, I wrote to him to explain that I would be happy to answer his queries at deposition. No suit was ever brought against me (I was never served). PHICO opened a file because of these threatening letters. The plaintiff was subsequently convicted of child sexual abuse and agreed to drop his claims against me and the hospital. I was notified that PHICO closed this file in August 1996.

I hope that this information clarifies any questions which might arise should you find that PHICO had carried an open case with my name on it. If you have any questions, please feel free to call me at 863 9001.

Sincerely yours,

Susan F. Smith, M.D.
SFS/ss
Enclosures

Cheryl A. Gibson, M.D. / Susan F. Smith M.D.
23 Mansfield Avenue, Burlington, Vermont 05401 • 802-863-9001 • Fax: 802-863-4951

PAUL, FRANK & COLLINS, INC.
ATTORNEYS AT LAW
ONE CHURCH STREET
P.O. BOX 1307
BURLINGTON, VERMONT 05402-1307

TELEPHONE (802) 658-2311
TELECOPIER (802) 658-0042

R. Allan Paul
Joseph E. Frank
Peter M. Collins
John T. Sartore (NY)
B. Michael Frye
Anthony B. Lamb
Alan D. Port
Robert G. Cain (NY)
S. Crocker Bennett, II
Robert S. DiPalma
Stephen J. Soule (NH)
Gail E. Haefner
Stephanie J. Mapes
Kenneth R. Appleby (DC, MD)

Stephen G. Norten
Christopher McVeigh (NE, NY)
John H. Draper, IV
Jan E. Bernasconi (MA)
David Borsykowsky (NY)
Matthew E.C. Pifer
William D. Riley
Mark G. Hall
April Shafer Johnson
David J. Spielman
John G. Beiswenger

Elizabeth J. Grant (MA)
Robert J. Grenier (MA)
OF COUNSEL

October 28, 1994

Mr. Scott Liebel
PHICO Insurance Company
P. O. Box 1482
Burlington, Vermont 05402-1482

October 28, 1994

11/9/94
This is a suit but he used a form for civil right action.
Until I am served, I have not been sued.

Re: Insured: Susan Fay Smith, M.D.
Claimant: Ann Handson
Date/Loss: 2/8/93
Claim No: 04 IP VT 215958

Dear Scott:

I can now shed some light on the above-referenced "civil rights" medical malpractice lawsuit, which is one of the stranger matters we have encountered recently. Plaintiff, who is *pro se* (and currently incarcerated), has filed his complaint in the Franklin Superior Court; it was filed on September 28, 1994. He has not, however, managed to effect service on your insured, Dr. Smith, as of yet. He has until November 28th to make this service. Interestingly, he does appear to have effected service on MCHV.

While we still do not understand those allegations of the complaint that hint at medical malpractice, we now can place them in a complete factual context: plaintiff has been charged with sexual abuse of his daughter (the "birth child" referenced in the complaint). These charges followed Dr. Smith's examination of the child, who was brought in by her mother.

The defendant/plaintiff has now brought a civil rights action against two state's attorneys, the hospital, and Dr. Smith, and perhaps others as well. Presumably, the obscure references to "hiding information" has something to do with Mr. Handson's attempts to conduct pre-trial discovery in the criminal case.

The criminal proceedings have been under way for some time, and Dr. Smith was deposed in connection with those proceedings on October 14th. She informs me that this deposition was limited strictly to matters relevant to the criminal proceedings. I will obtain a transcript as quickly as possible. I also have a call in to Linda Purdy, the state's attorney primarily assigned to the criminal case.

We send a notice to court that says S Norton is my lawyer so he always gets copies

I will be filing our notice of appearance with the court today. Otherwise, we can simply wait to see whether Mr. Handson completes service of process with respect to Dr. Smith.

Please call with any comments or questions.

Sincerely yours,

PAUL, FRANK & COLLINS, INC.

Stephen G. Norten

SGN:bac
cc: Susan Smith, M.D.
Ms. Nancy L. Levy
Ms. Geraldine Amori
DIA3:[USER.BCOUTU.WP.SGN.PHICHAND]LIEBEL.

PAUL, FRANK & COLLINS, INC.
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Christopher McVeigh (NE, NY)
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Jan E. Bernasconi (MA)
David Borsykowsky (NY)
Matthew E.C. Pifer
William D. Riley
Mark G. Hall
April Shafer Johnson
David J. Spielman (OH)
John G. Beiswenger
Diana C. Agnew (CO)
Christin Lahiff

Robert J. Grenier (MA)
OF COUNSEL

March 1, 1995

Mr. Scott Liebel
PHICO Insurance Company
P. O. Box 1482
Burlington, Vermont 05402-1482

Re: Insured: Susan Fay Smith, M.D.
Claimant: Ann Handson
Date/Loss: 2/8/93
Claim No: 04 IP VT 215958

Dear Scott:

I am writing to report on the success of our motion to dismiss filed in the above-referenced matter. Earlier today I attended a hearing on the motion in Franklin Superior Court. Judge Kilburn presided over the hearing and Mr. Handson, appearing pro se, participated via telephone. In short, Mr. Handson agreed to drop his claims against both Dr. Smith and the Medical Center Hospital of Vermont.

We will keep our file open until we receive the court's order dismissing the plaintiffs' complaint. If you should have any questions with regard to the above, please do not hesitate in contacting me.

Yours truly,

PAUL, FRANK & COLLINS, INC.

David J. Spielman, Esq.

DJS:srm
cc: Susan Smith, M.D.
Ms. Nancy L. Levy
Ms. Geraldine Amori
DIA3:[USER.SMILBA.WP.DJS]3157.82LIEBEL

PAUL, FRANK & COLLINS, INC.

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Mr. Scott Liebel
PHICO Insurance Company
P. O. Box 1482
Burlington, Vermont 05402-1482

October 24, 1995

Re: Insured: Susan Fay Smith, M.D.
Claimant: Ann Handson
Date/Loss: 2/8/93
Claim No: 04 IP VT 215958

COPY

Dear Scott,

Because the above-referenced matter was dismissed on the record during the hearing held before Judge Cashman on March 1, 1995, an Order of Dismissal was never issued. Nonetheless, I have enclosed herewith a copy of the Court's docket sheet noting the dismissal. As we can now be certain that the Court has closed its file, we will do the same with ours.

If you have any questions with regard to the above or enclosed, please do not hesitate in contacting me.

Yours truly,

PAUL, FRANK & COLLINS, INC.

David J. Spielman, Esq.

DJS/csg
Enclosure
cc: Susan Smith, M.D.
Ms. Nancy L. Levy
Ms. Geraldine Amori
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JURY

S 359-94 FC

CARL R. HANDSON VS. DR. SUSAN SMITH, F.M.D., AND MEDICAL CENTER HOSPITAL OF VERMONT

CIVIL RIGHTS COMPLAINT

Pro Se

Stephen G. Norten/Smith
P.O. Box 1307
Burlington, Vt. 05402-1307
658-2311

1994-Sep. 28: Civil Rights Complaint, Pro Se Appearance form and cert of service filed. IFP submitted

Oct. 18: IFP granted - E&D

Oct. 25: Corresp. from atty. Berger to court- inquiring if there has been a return of service in this matter fi by ptf.

Nov. 2: Notice of appearance of atty. Norten/Smith fi.

Dec. 5: Defts.Smith's motion to dismiss with memo fi.

199 1995- Jan. 12: Letter from Atty. spielman, to court-requesting Dr. Smith's motion to dismiss be carried out-ptf has not responded to any party concerning motion.

Feb. 15: Corresp. to court from atty. Norten-concerning motion to dismiss.

Mar. 01: Cashman/Tape- Hg on record - Dismissed by agreement of parties.

Oct. 20: Tele W/Atty Speilman - requesting copy of docket sheet - sent-gmbl